

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155338</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 , 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/30/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - PRESTWICK</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>445 S CR 525 E</b> <b>AVON, IN 46123</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Quality Assurance Walk-thru Survey conducted on 07/03/12 was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/30/12</p> <p>Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</p> <p>At this PSR survey, Manorcare Healthcare Services was found in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 02, a 20 bed addition built after March 1, 2003 and Building 01, built prior to March 1, 2003 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Fifteen resident rooms on the 800 wing have hard wired smoke detectors. Resident rooms on the 100, 200, 300, 600, and 700 wings have battery operated smoke detectors provided. The facility has a capacity of 140 and had a census of 94 at the time of this survey</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p>			{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	Continued From page 1			{K 000}			
	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.						
	Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/31/12.						
{K 000}	INITIAL COMMENTS			{K 000}			
	A Post Survey Revisit (PSR) to the Quality Assurance Walk-thru Survey conducted on 07/03/12 was conducted by the Indiana State Department of Health.						
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{K 000}	<p>Continued From page 2</p> <p>600, and 700 wings have battery operated smoke detectors provided. The facility has a capacity of 140 and had a census of 94 at the time of this survey</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/31/12.</p>	{K 000}			